DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 01-011

2. STATE: Indiana

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
September 17, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 0
b. FFY 2002 $ 0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19A, Pages 1A - 1H

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19A, Pages 1A - 1G

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Kathleen D. Gifford

13. TYPED NAME:
Kathleen D. Gifford

14. TITLE:
Assistant Secretary, OMPP

15. DATE SUBMITTED:
9/4/01

16. RETURN TO:
Kathleen Gifford
Assistant Secretary
Office of Medicaid Policy & Planning
402 West Washington, Rm W382
Indianapolis, IN 46204
ATTN: Tracy Brunner, Plan Coordinator

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 9/6/01

18. DATE APPROVED: 10/30/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
9/17/01

20. SIGNATURE OF REGIONAL OFFICIAL:
Cheryl A. Harris

21. TYPED NAME:
Cheryl A. Harris

22. TITLE: Associate Regional Administrator
Division of Medicaid and Children's Health

23. REMARKS:

RECEIVED
SEP 06 2001
DMCH - IL/IN/OH

FORM HCFA-179 (07-92)

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REIMBURSEMENT FOR INPATIENT HOSPITAL SERVICES

DEFINITIONS

"Allowable costs" means Medicare allowable costs as defined by 42 USC 1395 (f)

"All patient DRG grouper" refers to a classification system used to assign inpatient stays to DRGs.

"Base amount" means the rate per Medicaid stay that is multiplied by the relative weight to determine the DRG rate.

"Base period" means the fiscal years used for calculation of the prospective payment rates including base amounts and relative weights.

"Capital costs" are costs associated with the capital costs of the facility. Capital costs include, but are not limited to, the following:

(1) Depreciation.
(2) Interest.
(3) Property taxes.
(4) Property insurance.

"Children's hospital" means a free-standing general acute care hospital licensed under IC 16-21 that:

(1) is designated by the Medicare program as a "children's hospital"; or
(2) furnishes services to inpatients who are predominantly individuals under the age of eighteen (18), as determined using the same criteria used by the Medicare program to determine whether a hospital's services are furnished to inpatients who are predominantly individuals under the age of eighteen (18).

"Cost outlier case" means a Medicaid stay that exceeds a predetermined threshold defined as the greater of twice the DRG rate or a fixed dollar amount established by the office. This amount may be changed at the time DRG relative weights are adjusted.

"Diagnosis-related group" or "DRG" means a classification of an inpatient stay according to the principal diagnosis, procedures performed, and other factors that reflect clinically cohesive groupings of inpatient hospital stays using similar resources. Classification is made using the all-patient (AP) DRG grouper.

"Discharge" means the release of a patient from an acute care facility. Patients may be discharged to their home, another health care facility, or due to death. Transfers from one (1) unit in a hospital to another unit in the same hospital shall not be considered a discharge, unless one (1) of the units is paid according to the level-of-care approach.

"DRG daily rate," means the per diem payment amount for a stay classified into a DRG calculated by dividing the DRG rate by the DRG average length of stay.

"DRG rate" means the product of the relative weight multiplied by the base amount. It is the amount paid to reimburse hospitals for routine and ancillary costs of providing care for an inpatient stay.

"Free-standing" hospital does not mean a wing or specialized unit within a general acute care hospital.

"Hospital Market Basket Index" or "Market Basket Index" or "Index" means the DRI-Type Hospital Market Basket Index, published quarterly by DRI/McGraw Hill in "Health Care Costs".

"Inpatient" means a Medicaid patient who was admitted to a medical facility on the recommendation of a physician and who received room, board and professional services in the facility.

"Inpatient hospital facility" means a general acute care hospital, a mental health institution, a state mental health institution or a rehabilitation inpatient facility properly licensed as a hospital in accordance with appropriate Indiana Code.

"Less than one-day stay" means a medical stay of less than twenty-four (24) hours that is paid according to a DRG rate.

"Level-of-care case" means a medical stay that includes psychiatric cases, rehabilitation cases, certain burn cases and long term care hospital admissions.

"Level-of-care rate" means a per diem rate that is paid for treatment of a diagnosis or performing a procedure.

"Long term care hospital" means a free-standing general acute care hospital licensed under IC 16-21 that:

(1) is designated by the Medicare program as a "long term hospital"; or
(2) has an average inpatient length of stay greater than twenty-five (25) days, as determined using the same criteria used by the Medicare program to determine whether a hospital's average length of stay is greater than twenty-five (25) days.

"Medicaid day" means any part of a day, including the date of admission, for which a patient enrolled with the Indiana Medicaid program is admitted as an inpatient and remains overnight. The day of discharge is not considered a Medicaid day.

"Medicaid stay" means an episode of care provided in an inpatient setting that includes at least one (1) night in the hospital and is covered by the Indiana Medicaid program.

"Medical education costs" means the costs that are associated with the salaries and benefits of medical interns and residents and paramedical education programs.

"Office" means the Office Medicaid Policy and Planning of the Indiana Family and Social Services Administration.

"Outlier payment amount" means the amount reimbursed in addition to the DRG rate for certain inpatient stays that exceed cost thresholds established by the office.

"Per diem" means an all-inclusive rate per day that includes routine and ancillary costs and capital costs.

"Principal diagnosis" means the diagnosis, as described by ICD-9-CM code, for the condition established after study to be chiefly responsible for occasioning the admission of the patient for care.

"Readmission" means that a patient is admitted into the hospital within fifteen (15) days following a previous hospital admission and discharge for a related condition as defined by the office.

"Rebasing" means the process of adjusting the base amount using more recent claims data, cost report data, and other information relevant to hospital reimbursement.

"Relative weight" means a numeric value that reflects the relative resource consumption for the DRG to which it is assigned. Each relative weight is multiplied by the base amount to determine the DRG rate.

"Routine and ancillary costs" means costs that are incurred in the providing services exclusive of medical education and capital costs.

"Transfer" means a situation in which a patient is admitted to one (1) hospital and is then released to another hospital during the same episode of care. Movement of a patient from one (1) unit within the same hospital will not constitute a transfer unless one (1) of the units is paid under the level-of-care reimbursement system.

"Transferee hospital" means the hospital that accepts a transfer from another hospital.

"Transferring hospital" means the hospital that initially admits then discharges the patient to another hospital.

PROSPECTIVE REIMBURSEMENT METHODOLOGY

The purpose of this section is to establish a prospective reimbursement methodology for services provided by inpatient hospital facilities that are covered by the state of Indiana Medicaid program. The methodology for reimbursement described in this section shall be a prospective

system wherein a payment rate for each hospital stay will be established according to a DRG reimbursement methodology or a level-of-care reimbursement methodology. Prospective payment shall constitute full reimbursement. There shall be no year-end cost settlement payments.

Inpatient stays reimbursed according to the DRG methodology shall be assigned to a DRG using the all-patient DRG grouper. The DRG rate is equal to the relative weight multiplied by the base amount.

Payment for inpatient stays reimbursed according to the DRG methodology shall be equal to the sum of the DRG rate, the capital rate, the medical education rate if applicable, and, the outlier payment amount, if applicable.

Payment for inpatient stays reimbursed as level-of-care cases shall be equal to the sum of the per diem rate for each Medicaid day, the capital rate, the medical education rate if applicable, and the outlier payment amount, if applicable.

Relative weights will be reviewed annually by the office and adjusted no more often than every second year using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. After January 1 2002, relative weights will be reviewed by the office and adjusted annually using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the relative use of hospital resources. Interim adjustments to the relative weights will not be made except in response to legislative mandates affecting Medicaid participating hospitals. Each legislative mandate will be evaluated individually to determine whether an adjustment to the relative weights will be made. DRG average length of stay values will be revised when relative weights are adjusted.

A base amount is the rate per Medicaid stay. DRG base amounts will be reviewed annually by the office and adjusted no more often than every second year using the most recent reliable claims data and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. In the absence of rebasing, the base amounts will be inflated using the most recently available DRI/McGraw Hill Hospital Market Basket Index. Rebasing of the base amount will apply information from the most recent available cost report that has been filed and audited by the office or its contractor.

The office may establish a separate base amount for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate base amount. Children's hospitals with a case mix adjusted cost per discharge greater than one standard deviation above the mean cost per discharge for DRG services will be eligible to receive the separate base amount established under this subsection. The separate base amount is equal to one hundred and twenty percent (120%) of the statewide base amount for DRG services.

Level-of-care rates are per diem rates. Level-of-care rates will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data

and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the cost of efficiently providing hospital services. In the absence of rebasing, the base amounts will be inflated using the most recently available DRI/McGraw Hill Hospital Market Basket Index. Rebasing of the per diem rates will apply information from the most recent available cost report that has been filed and audited by the office or its contractor. The office shall not set separate level-of-care rates for different categories of facilities, except as specifically noted in this section.

Level-of-care cases are categorized as DRG numbers 424-428, 429 (excluding diagnosis code 317.XX – 319.XX), 430-432, 456-459, 462, and 472, as defined and grouped using the all patient DRG grouper, version 14.1. These DRG numbers represent burn, psychiatric, and rehabilitative care. The office may assign a LOC DRG number for long term care hospital admissions.

In addition to the burn level-of-care rate, the office may establish an enhanced burn level-of-care rate for hospitals with specialized burn facilities, equipment, and resources for treating severe burn cases. In order to be eligible for the enhanced burn rate, facilities must be designated by the state department of health as offering a burn intensive care unit.

The office may establish separate level-of-care rates for children's hospitals to the extent necessary to reflect significant differences in cost. Each children's hospital will be evaluated individually for eligibility for the separate level-of-care rate. Children's hospitals with a cost per day greater than one standard deviation above the mean cost per day for level-of-care services will be eligible to receive the separate base amount. Determinations will be made for each level-of-care category. The separate base amount is equal to one hundred twenty percent (120%) of the statewide level-of-care rate.

After January 1 2002, the office may establish separate level-of-care rates, policies, billing instructions, and frequency for long term care hospitals to the extent necessary to reflect differences in treatment patterns for patients in such facilities. Hospitals must meet the definition of a long term care hospital to be eligible for the separate level-of-care rate.

Add-On Payments

Capital payment rates cover capital costs. Capital costs are costs associated with the ownership of capital and include the following:

- Depreciation
- Interest
- Property Taxes
- Property insurance

Capital payment rates shall be prospectively determined and shall constitute full reimbursement for capital costs. Capital payment rates will be calculated using a minimum occupancy level for non-nursing beds of 80 percent. Capital per diem rates will be reviewed annually by the office and adjusted no more often than every second year by using the most recent reliable claims data

and cost report data to reflect changes in treatment patterns, technology, and other factors that may change the capital costs associated with efficiently providing hospital services. In the absence of rebasing, the per diem capital rate will be inflated annually using the Hospital Market Basket Index. The capital payment amount is calculated as follows:

- for stays reimbursed under the DRG methodology, capital payment is equal to the product of the per diem capital rate and the average length of stay for the assigned DRG. Capital payments shall be pro-rated for a transferring facility to a maximum of the average length of stay.
- for stays reimbursed under the level-of-care methodology, capital payment is equal to the product of the per diem capital rate for each covered day of care.

The office shall not set separate capital per diem rates for different categories of facilities, except as specifically noted in this plan.

Medical Education rates shall be prospective, hospital-specific per diem amounts. Medical education payment amounts are calculated as follows:

- for stays reimbursed under the DRG methodology, medical education payments are equal to the product of the medical education per diem rate and the average length of stay assigned to the DRG. Medical education rates for a transferring facility shall be pro-rated not to exceed the average length of stay.

- for stays reimbursed under the level-of-care methodology, medical education payments are equal to the medical education per diem rate for each covered day of care.

Medical education rates are "facility-specific rates based on costs per resident per day multiplied by the number of residents reported by the facility. No more often than every second year, the office will use the most recent cost report data to determine a cost per resident per day that more accurately reflects the cost of efficiently providing hospital services as it relates to operating a medical education program. The number of residents will be determined according to the most recent available cost report that has been filed and audited by the office or its contractor. In the absence of rebasing, the medical education per diem will be inflated annually using the Hospital Market Basket Index.

Medical education payments will be available to hospitals only so long as they continue to operate medical education programs. Hospitals must notify the office within thirty (30) days following discontinuance of their medical education program. For hospitals establishing new medical education programs, the medical education per diem will be effective no earlier than two (2) months before notification to the office that the program has been implemented. The medical education per diem shall be based on the most recent reliable claims data cost report data.

A Medicaid stay that exceeds a predetermined threshold, defined as the greater of: (1) twice the DRG rate or (2) the outlier threshold, is a cost outlier case. The calculation for outlier payment amounts is made as follows:

(1) Multiplying the overall facility cost-to-charge ratio by submitted charges. The outlier payment is equal to 60 percent of the difference between the prospective cost per stay and the greater of the DRG rate or the outlier threshold amount.

(2) Day outliers as required under Section 1902 (s) of the Social Security act are provided for through implementation of the DRG/LOC per diem, which is designed to account for unpredictable and lengthy hospital admissions.

Outlier thresholds will be revised as necessary when DRG relative weights are adjusted. Cost outlier payments are not available for cases reimbursed using the level-of-care methodology, except for burn cases that exceed the established threshold.

Other Payment Policies

Readmissions will be treated as separate stays for payment purposes but will be subject to medical review. If it is determined that a discharge is premature, payments made as a result of the discharge/readmission may be subject to recoupment.

The transferee hospital (hospital that accepts a transfer from another hospital) is paid according to the DRG or level-of care methodology.

The transferring hospital (hospital that initially admits then discharges the patient to another hospital) is paid on a pro-rata basis up to the full payment amount, including capital, medical education as applicable, and cost outliers as applicable.

Certain DRGs are established for transfer cases only. For these DRGs, reimbursement shall be equal to the DRG rate.

Each facility that submits an Indiana Medicaid cost report will receive a cost-to-charge ratio. The cost-to-charge ratio will be computed from claims data and will be used to determine applicable cost outlier payments. Facilities with less than 30 Medicaid claims annually will be given the statewide median cost-to-charge ratio.

Special payment policies shall apply to less than one-day stays that are paid according to a DRG rate. For less than one-day stays, hospitals will be paid a DRG daily rate, the capital per diem rate for one (1) day of stay, and the medical education per diem rate (if applicable) for one (1) day of stay.

Out-of-state hospitals receive the same DRG and level-of-care payments that are made for the same service to instate facilities computed in accordance with this plan. Out-of-state facilities will use a statewide median cost-to-charge ratio to determine applicable cost outlier payments, computed in accordance with the outlier provisions of this plan.

To be eligible for a facility-specific per diem medical education rate, out-of-state providers must be located in a city listed in 405 IAC 5-5-2(a)(3) through 405 IAC 5-5-2(a)(4) or have a

minimum of sixty (60) Indiana Medicaid inpatient days annually. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for this reimbursement.

To be considered for a separate base amount for children's hospitals, out-of-state children's hospitals must be located in a city listed in 405 IAC 5-5-2(a)(3) through 405 IAC 5-5-2(a)(4) or have a minimum of sixty (60) Indiana Medicaid inpatient days annually. Providers must submit annually an Indiana Medicaid hospital cost report to be eligible for a separate base amount.